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RE-THINKING HEALTH LITERACY IN REMOTE COMMUNITIES

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The Yolŋu Studies Department at Charles Darwin University was commissioned by government to develop a project: Health literacy and health interpreting in the East Arnhem region. We proposed three new approaches:

1: Systemic Health Literacy

Effective health literacy has largely to do with effective communication, taking into account the demands of health service delivery and the demands of everyday life in a remote Aboriginal community. It is not so much what the individual client knows about biomedicine, but more the working together of the people and resources which generate shared understandings and agreement.[1] It involves honest respectful discussion across the divide between providers and consumers. Health literacy is a not a structural problem so there are no structural solutions.

2: Front line policy work.

Present attempts to improve Aboriginal health communication and literacy tend to utilize a top-down policy approach which seems to blame the client for irresponsible life choices and ways, and front line workers for poor delivery. Yet health professionals, clients and families are often using their discretion to create good open collaborative ways of working together.

We understand "policy" as the cumulative effect of the individual decisions made by front line workers producing slow but effective and evidence-based bottom-up changes to policy. (See the work of Lipsky 1980.[2]) We find what's working on the ground, we support it, we join up people and resources, and we celebrate, document and publicise successful practices together. Good policy promotes good local organisational culture and vice versa.

3: Conversations across borders

Resources that contain health messages seldom stimulate conversations which promote new productive collaborations across the boundaries between health professionals, service users and their families. They tend to entrench definitions, roles and attitudes rather than modify them. We propose an additional, radically different resource,[3] a user-friendly touch-pad animation of a human body which has no message, no sequence. It is manipulable, zoomable, transparent, detailed in particular areas (heart, lungs, kidneys, liver, pancreas, ears), yet de-emphasises biomedical assumptions: not telling you how to behave, but crying out for a conversation – in any language. In all this piecemeal work, we promote new consistencies in the ways in which service users and providers approach their work. Real change comes when categories are unsettled, where we have conversations which allow us all to rethink our assumptions and our possibilities.

Graphics from the touch pad resource

Cass, A, Lowell, A, Christie, M, Snelling, P, Flack, M, Marrnganyin, B & Brown, I (2002), 'Sharing the true stories: improving communication between Aboriginal patients and healthcare workers', The Medical Journal of Australia, vol. 176, no. 10, pp. 466-70.

Lipsky, M. (1980). Street level bureaucracy: dilemmas of the individual in public services. New York: Russell Sage Foundation.

1 See our previous research, Cass et al, 2002, and www.cdu.edu.au/stts
2 See also www.cdu.edu.au/ice
3 An earlier version described at www.cdu.edu.au/centres/hl/PDF/CHEI-iPad-SpecS.pdf